

General New Patient Forms

Name: _____ **Birth Date:** _____

Past Medical History: Please place a check mark in the according box if you or a family member has ever had any of the following. Immediate family and grandparents constitute pertinent family.

- | | | |
|---|---|---|
| 1. Diabetes: You <input type="checkbox"/> Family <input type="checkbox"/> | 6. Psychiatric Problem: You <input type="checkbox"/> Family <input type="checkbox"/> | 12. Heart Disease: You <input type="checkbox"/> Family <input type="checkbox"/> |
| 2. Thyroid: You <input type="checkbox"/> Family <input type="checkbox"/> | 7. High Blood Pressure: You <input type="checkbox"/> Family <input type="checkbox"/> | 13. Liver Function: You <input type="checkbox"/> Family <input type="checkbox"/> |
| 3. Seizures: You <input type="checkbox"/> Family <input type="checkbox"/> | 8. Lung Disease: You <input type="checkbox"/> Family <input type="checkbox"/> | 14. Kidney Disease: You <input type="checkbox"/> Family <input type="checkbox"/> |
| 4. TB: You <input type="checkbox"/> Family <input type="checkbox"/> | 9. Kidney Stones: You <input type="checkbox"/> Family <input type="checkbox"/> | 15. Urine Infection: You <input type="checkbox"/> Family <input type="checkbox"/> |
| 5. Cancer: You <input type="checkbox"/> Family <input type="checkbox"/> | 10. Bleeding Problems: You <input type="checkbox"/> Family <input type="checkbox"/> | 16. Infertility: You <input type="checkbox"/> Family <input type="checkbox"/> |
| Type of cancer? _____ | 11. Anesthesia Problems: You <input type="checkbox"/> Family <input type="checkbox"/> | |

Are you allergic to any medications? If yes, list here _____

Past Gynecological History (Women Only): 1. Last Menstrual Period _____ 2. # of Pregnancies _____ 3. Live Births _____
 4. Last PAP _____ 5. Last Mammogram or Breast Thermography _____

Family Medical History:

Disease Or Cause Of Death

- | | | |
|----------------------|---|-------|
| 1. Father Age _____ | Living <input type="checkbox"/> Deceased <input type="checkbox"/> | _____ |
| 2. Mother Age _____ | Living <input type="checkbox"/> Deceased <input type="checkbox"/> | _____ |
| 3. Brother Age _____ | Living <input type="checkbox"/> Deceased <input type="checkbox"/> | _____ |
| 4. Brother Age _____ | Living <input type="checkbox"/> Deceased <input type="checkbox"/> | _____ |
| 5. Sister Age _____ | Living <input type="checkbox"/> Deceased <input type="checkbox"/> | _____ |
| 6. Sister Age _____ | Living <input type="checkbox"/> Deceased <input type="checkbox"/> | _____ |

Social History:

Single Married Divorced Widowed

Do You Or Have You Ever Used Tobacco? _____ If Yes, How Much/Frequency? _____ If Quit, When? _____

Review Of Systems

Do you now or have you ever had problems with any of the following?
 (Please circle your answer and add additional details on back side of this form.)

General: Change in Weight Fever Night Sweats Fatigue Insomnia

Skin: Lumps or Nodules Breast Lump Rashes Sores Dry Skin Abnormal Mole
 Other Skin Problems _____

Eyes: Glaucoma Blurry Vision Cataracts Glasses Contacts Itchy Eyes
 Other Eye Problems _____

ENT: Trouble Swallowing Sore Throat Snoring Nose Bleeds Dentures Sneezing Hoarseness
 Sinus Problems Buzzing in Ears Earaches

Heme/Lymph: Swollen Nodes or Glands Bleeding Anemia Other Blood Disorders _____

C/V: Irregular Heart Beat Heart Failure Angina Chest Pain Heart Valve Problem Heart Murmur
 Pain in Legs with Exertion Phlebitis Swelling In Legs Blood Clots High Blood Pressure Other Heart Problems

Respiratory: Shortness of Breath Colored Sputum Cough Asthma Other Lung Problems _____

G/I: Gall Bladder Problems Blood in Stool Dark Tarry Stools Intestinal Bleeding Hemorrhoids Ulcer
 Poor Appetite Hiatal Hernia Indigestion Hernia Nausea Vomiting Diarrhea Constipation

G/U System: Pain or Burning With Urination Kidney Stone Frequency Slow or Small Stream Blood in Urine
 Getting Up At Night to Urinate Leaking of Urine Urgency to Go Poor Bladder Emptying
 Sexual Problem Abnormal Vaginal Bleeding Menstrual Problems Recurrent Urine Infection

Neuro: Loss of Consciousness Headaches Dizziness Strokes Seizures Paralysis Numbness
 Weakness Faintness Tremors Change in Handwriting

Psych: Depression Suicidal Thoughts Anxiety Stress Memory Problems Other Psychological Problem

Musculoskeletal: Joint Replacement Surgery Broken Bones Gout Arthritis Bone Pain Joint Pain Muscle Pain

Endocrine: Heat or Cold Intolerance Hot Flashes Flushing Abnormal Thirst Change in Body Hair
Skin Pigmentation Changes

Do you have any other issues you would like to discuss with the doctor? Yes (Describe Below) No

Patient Signature _____

Date _____